SERFF Tracking Number:	*AMRP-125802357*	*State:*	*Arkansas*
Filing Company:	*American Republic Corp Insurance Company*	*State Tracking Number:*	*40245*
Company Tracking Number:	*11AR0508*		
TOI:	*MS05I Individual Medicare Supplement - Standard Plans*	*Sub-TOI:*	*MS05I.001 Plan A*
Product Name:	*Medicare Supplement*		
Project Name/Number:	*/*		

Filing at a Glance

Company: American Republic Corp Insurance Company

Product Name: Medicare Supplement	SERFF Tr Num: AMRP-125802357	State: ArkansasLH
TOI: MS05I Individual Medicare Supplement - Standard Plans	SERFF Status: Closed	State Tr Num: 40245
Sub-TOI: MS05I.001 Plan A	Co Tr Num: 11AR0508	State Status: Approved-Closed
Filing Type: Form/Rate	Co Status: Submitted to State	Reviewer(s): Stephanie Fowler
	Authors: Norm Von Seggern, Susan Zaiger, Susan Falk, Beverly Shuey, Michele Kulish, Andrea Nelson, Leroy Edge, Kerin Overturf	Disposition Date: 11/20/2008
	Date Submitted: 09/12/2008	Disposition Status: Approved
Implementation Date Requested: 11/01/2008		Implementation Date:

State Filing Description:

General Information

Project Name:	Status of Filing in Domicile:
Project Number:	Date Approved in Domicile:
Requested Filing Mode:	Domicile Status Comments:
Explanation for Combination/Other:	Market Type:
Submission Type:	Group Market Size:
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 11/20/2008	
State Status Changed: 11/20/2008	Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

RE: INDIVIDUAL MEDICARE SUPPLEMENT INSURANCE

C-1042AR – Medicare Supplement Policy Plan A

C-1043AR – Medicare Supplement Policy High Deductible Plan F

C-1044AR – Medicare Supplement Policy Plan J

SERFF Tracking Number:	*AMRP-125802357*	*State:*	*Arkansas*
Filing Company:	*American Republic Corp Insurance Company*	*State Tracking Number:*	*40245*
Company Tracking Number:	*11AR0508*		
TOI:	*MS05I Individual Medicare Supplement - Standard Plans*	*Sub-TOI:*	*MS05I.001 Plan A*
Product Name:	*Medicare Supplement*		
Project Name/Number:	*/*		

C-1042-1 – Outline of Medicare Supplement Coverage

Actuarial Memorandum and Rates

Enclosed are the above captioned Medicare Supplement forms for your review. These are new forms and do not replace any existing forms currently on file with your department.

With these products, American Republic Corp Insurance Company will offer a separate set of Medicare Supplement plans (Plans A, High Deductible F and J) marketed to customers who contact us for coverage, either on-line or through our inbound call center. We intend to offer these plans in addition to any Medicare Supplement plans marketed through face to face contact with an agent and through out going telephone direct marketing sales.

In the course of researching the feasibility of this approach we discovered that both the NAIC Model Regulation as well as Arkansas Insurance Department Final Rules seems to allow for more than one of each particular plan in a state. Arkansas Insurance Department Rule 27, Minimum Standards for Medicare Supplement Policies, Section 15 (D) (2) states that an issuer may offer up to four additional policy or certificate forms of the same type for the same standard Medicare supplement benefit plan. The provision does state that one of the cases a company may have more than one Medicare supplement plan with the addition of either direct response or producer marketing methods, of which into our situation would fall.

These forms are filed separately and have separate and distinct policy form numbers that differ from those that are currently on file with your Division.

We feel offering a dual set of the plans is warranted. We have researched the market and have found that more and more Medicare eligible individuals are comfortable purchasing the product without the need of an agent to offer support throughout the process and many seem to prefer not to have an agent present. Under our current system we provide the agent a commission on each sale, a cost that gets passed on to the consumer. The senior health care customer and market are changing and we see this as an opportunity to continue to meet the market demand. We would offer a lower price point for customers that are comfortable with this approach.

Policy Form C-1042AR provides all of the benefits required under a Medicare Supplement Plan A policy. Under Hospitalization it covers Part A coinsurance plus coverage for 365 additional days after Medicare benefits end. Under

Medical Expenses it covers Part B coinsurance, or copayments for hospital outpatient services and under Blood it will cover the first 3 pints of blood each year.

Policy Form C-1043AR is High Deductible Plan F. It provides all Plan A benefits plus coverage for skilled nursing coinsurance, Part A deductible, Part B deductible, Part B excess and foreign travel emergency after the covered person has paid a calendar year deductible. This deductible amount is determined by CMS each year.

Policy form C-1026AR is the Medicare Supplement Policy Plan J. It provides all Plan A benefits plus coverage for skilled nursing coinsurance, Part A deductible, Part B deductible, Part B excess, foreign travel emergency, at-home recovery and preventive care not covered by Medicare. The prescription drug benefit is not included.

C-1042-1 is the Outline of Coverage we will use with these Medicare Supplement Policies. It follows the Outline of Coverage set out in the NAIC Model Minimum Standards Regulation.

We will be using application form C-1031 for the solicitation of this product. Form C-1031 was filed and approved by your Department on February 27, 2008. Please refer to SERFF Tracking Number AMRP-125379102; State Tracking Number 37844; and Company Tracking Number: 11AR0505.

The Actuarial Memorandum and rates are included with this filing.

Variable material is bracketed to indicate that they are subject to change. The forms are in final print subject only to minor modifications in paper size, stock, color, border, font, company logo and adaptation to computer printing. Depending on printer capabilities, the application will be printed as either simplex or duplex.

We hope these forms will meet with your approval. If you have any questions or comments, please contact me. I can be reached at 800-247-2190 extension 2248 (telephone), 515-247-2558 (fax), or you may e-mail me at IDR@AmericanEnterprise.com.

SERFF Tracking Number:	*AMRP-125802357*	*State:*	*Arkansas*
Filing Company:	*American Republic Corp Insurance Company*	*State Tracking Number:*	*40245*
Company Tracking Number:	*11AR0508*		
TOI:	*MS05I Individual Medicare Supplement - Standard Plans*	*Sub-TOI:*	*MS05I.001 Plan A*
Product Name:	*Medicare Supplement*		
Project Name/Number:	*/*		

Company and Contact

Filing Contact Information

Susan Zaiger, Senior Product Analyst
601 6th Ave
Des Moines, IA 50334

susan.zaiger@americanenterprise.com
(515) 245-2248 [Phone]
(515) 247-2558[FAX]

Filing Company Information

American Republic Corp Insurance Company
P O Box 2780
Omaha, NE 68103-2780
(800) 987-8988 ext. [Phone]

CoCode: 67679
Group Code: 3527
Group Name: American Enterprise
FEIN Number: 23-1609793

State of Domicile: Nebraska
Company Type: Life and Health
State ID Number:

Filing Fees

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	No
Fee Explanation:	
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
American Republic Corp Insurance Company	$50.00	09/12/2008	22468828

SERFF Tracking Number:	*AMRP-125802357*	*State:*	*Arkansas*
Filing Company:	*American Republic Corp Insurance Company*	*State Tracking Number:*	*40245*
Company Tracking Number:	*11AR0508*		
TOI:	*MS05I Individual Medicare Supplement - Standard Plans*	*Sub-TOI:*	*MS05I.001 Plan A*
Product Name:	*Medicare Supplement*		
Project Name/Number:	*/*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Stephanie Fowler	11/20/2008	11/20/2008

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	**Created By**	**Created On**	**Date Submitted**	**Responded By**	**Created On**	**Date Submitted**
Pending Industry Response	Stephanie Fowler	11/14/2008	11/14/2008	Susan Zaiger	11/19/2008	11/19/2008

SERFF Tracking Number:	*AMRP-125802357*	*State:*	*Arkansas*
Filing Company:	*American Republic Corp Insurance Company*	*State Tracking Number:*	*40245*
Company Tracking Number:	*11AR0508*		
TOI:	*MS05I Individual Medicare Supplement - Standard Plans*	*Sub-TOI:*	*MS05I.001 Plan A*
Product Name:	*Medicare Supplement*		
Project Name/Number:	*/*		

Disposition

Disposition Date: 11/20/2008
Implementation Date:
Status: Approved
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*AMRP-125802357*	*State:*	*Arkansas*
Filing Company:	*American Republic Corp Insurance Company*	*State Tracking Number:*	*40245*
Company Tracking Number:	*11AR0508*		
TOI:	*MS05I Individual Medicare Supplement - Standard Plans*	*Sub-TOI:*	*MS05I.001 Plan A*
Product Name:	*Medicare Supplement*		
Project Name/Number:	*/*		

Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice	Approved	Yes
Supporting Document	Application	Approved	Yes
Supporting Document	Health - Actuarial Justification	Approved	No
Supporting Document	Outline of Coverage	Approved	Yes
Form	Medicare Supplement Policy Plan A	Approved	Yes
Form	Medicare Supplement Policy Plan High Deductible F	Approved	Yes
Form	Medicare Supplement Policy Plan J	Approved	Yes
Rate	Rates DTC AR	Approved	Yes

SERFF Tracking Number:	*AMRP-125802357*	*State:*	*Arkansas*
Filing Company:	*American Republic Corp Insurance Company*	*State Tracking Number:*	*40245*
Company Tracking Number:	*11AR0508*		
TOI:	*MS05I Individual Medicare Supplement - Standard Plans*	*Sub-TOI:*	*MS05I.001 Plan A*
Product Name:	*Medicare Supplement*		
Project Name/Number:	*/*		

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	11/14/2008
Submitted Date	11/14/2008
Respond By Date	12/15/2008

Dear Susan Zaiger,

This will acknowledge receipt of the captioned filing.

I apologize for the amount of time it has taken for me to review this filing. With that being said, could you please direct me to the rates, this is all I need in order to give these forms a final approval.

Thank you for your patience in this matter.

Please feel free to contact me if you have questions.
Sincerely,
Stephanie Fowler

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	11/19/2008
Submitted Date	11/19/2008

Dear Stephanie Fowler,

Comments:

Response 1

Comments: Thank you for your review of this filing. I apologize for omitting the rates from my original submission. I am including the rate information now.

If you need any additional information, please contact me.

Changed Items:

SERFF Tracking Number:	*AMRP-125802357*	*State:*	*Arkansas*
Filing Company:	*American Republic Corp Insurance Company*	*State Tracking Number:*	*40245*
Company Tracking Number:	*11AR0508*		
TOI:	*MS05I Individual Medicare Supplement - Standard Plans*	*Sub-TOI:*	*MS05I.001 Plan A*
Product Name:	*Medicare Supplement*		
Project Name/Number:	*/*		

No Supporting Documents changed.

No Form Schedule items changed.

Rate/Rule Schedule Item Changes

Document Name:	Affected Form Numbers:	Rate Action:	Rate Action Information:	Attach Document:
Rates DTC AR	C-1042AR, C-1043AR, C-1044AR	New	*Previous State Filing Number* *Percent Rate Change Request* 0	

Sincerely,
Andrea Nelson, Beverly Shuey, Kerin Overturf, Leroy Edge, Michele Kulish, Norm Von Seggern, Susan Falk, Susan Zaiger

SERFF Tracking Number:	*AMRP-125802357*	*State:*	*Arkansas*
Filing Company:	*American Republic Corp Insurance Company*	*State Tracking Number:*	*40245*
Company Tracking Number:	*11AR0508*		
TOI:	*MS05I Individual Medicare Supplement - Standard Plans*	*Sub-TOI:*	*MS05I.001 Plan A*
Product Name:	*Medicare Supplement*		
Project Name/Number:	*/*		

Form Schedule

Lead Form Number: C-1042AR

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved	C-1042AR	Policy/Contract/Fraternal Certificate	Medicare Supplement Policy Plan A	Initial		61	C-1042AR.pdf
Approved	C-1043AR	Policy/Contract/Fraternal Certificate	Medicare Supplement Policy Plan High Deductible F	Initial		58	C-1043AR.pdf
Approved	C-1044AR	Policy/Contract/Fraternal Certificate	Medicare Supplement Policy Plan J	Initial		55	C-1044AR.pdf

American Republic Corp
Insurance Company P.O. Box 2780, Omaha, NE 68103-2780

MEDICARE SUPPLEMENT INSURANCE

Notice to Buyer: This policy may not cover all of your medical expenses.

American Republic Corp Insurance Company and its agents are in no way connected with Medicare.

This is a Non Participating Policy.

American Republic Corp Insurance Company is a stock insurance company. We will pay the benefits of this policy under its terms, for injury occurring or sickness first manifested while it is in force. This policy is issued based upon the statements in the attached copy of the application and the payment of the first premium in advance of the date of issue.

30 DAY RIGHT TO EXAMINE POLICY

Please read this policy and the attached application carefully. If you are not satisfied with it for any reason, you may return it to us, or to the agent who took your application, together with a request for cancellation within 30 days after you receive it. You will be sent a full refund of any premium paid. Then the policy will be void from the beginning as if no policy had been issued.

GUARANTEED RENEWAL FOR LIFE

We will renew this policy for any covered person for life. We will renew this policy each time we receive the correct premium before the end of the grace period. While this policy is in force, we can't change its benefits without your consent, except as provided for in the BENEFITS Section. The term of coverage under this policy begins at 12:01 a.m., Standard Time, on the date of issue shown on the Validation of Coverage Page at the place where you reside. It ends at the same time on the renewal date shown on the Validation of Coverage Page. Each time this policy is renewed, a new term begins.

In witness whereof, American Republic Corp Insurance Company has caused this policy to be signed by its Executive Officers on the date of issue.

Michael E Abbott — President
Mary K Durand — Secretary
Paul K Mikkelsen — Countersignature

MEDICARE SUPPLEMENT POLICY PLAN A
Guaranteed Renewable For Life
The Company Can Change The Premium Rates By Class
Premiums May Change Because of A Change
Of Residence, Or As Medicare Benefits Change

TABLE OF CONTENTS

VALIDATION OF COVERAGE

COVERED PERSON (S):
[John A. Doe, age 65, the Insured]

POLICY NUMBER: [12345678]

DATE OF ISSUE: [NOVEMBER 1, 2008]

FIRST RENEWAL DATE: [varies, based on premium mode selected]

INITIAL PREMIUM AND FEES (if applicable): $ [####]

When we use “we” or “us” or “our,” we mean American Republic Corp Insurance Company, and when we use “you” or “your,” we mean the Insured.

SECTION 1

GUARANTEED RENEWAL FOR LIFE

We will renew this policy for any covered person for life. We will renew this policy each time we receive the correct premium before the end of the grace period.

While this policy is in force, we can’t change its benefits without your consent, except as provided for in Section 2. The term of coverage under this policy begins at 12:01 a.m., Standard Time, on the date shown on the Validation of Coverage Page at the place where you reside. It ends at the same time on renewal date shown on the Validation of Coverage Page. Each time this policy is renewed, a new term begins.

SECTION 2

BENEFITS

We will pay for a covered person’s eligible expenses listed below that are approved but not paid for by Medicare (PART A) Hospital Insurance and Medicare (PART B) Medical Insurance. In determining benefits to be paid, we will consider the covered person to be enrolled in and eligible for Medicare Parts A and B. The eligible expenses must be incurred during the benefit period while this policy is in force. The eligible expense must be medically necessary and reasonable as set by Medicare and must result from an injury or sickness unless specifically provided. Benefits will be changed automatically to coincide with any change in the Medicare deductibles and coinsurance amounts.

BASIC (CORE) PLAN BENEFITS

(1) MEDICARE PART A HOSPITAL SERVICES AND SUPPLIES EXPENSES

(A) Medicare PART A eligible expenses for hospitalization from the 61st to the 90th day in any Medicare benefit period;

(B) Medicare PART A eligible expenses for hospitalization for each Medicare lifetime inpatient reserve day used; and

(C) When all Medicare hospital inpatient coverage and lifetime reserve days are used up, we will pay 100% of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum of an additional 365 days. The provider shall accept the issuer’s payment as payment in full and may not bill the covered person for any balance.

(2) MEDICARE PART A AND PART B BLOOD DEDUCTIBLES
Coverage under Medicare PARTS A and B for the first three pints of blood (whole blood or units of packed red blood cells) unless replaced in accordance with federal regulations.

(3) MEDICARE PART B MEDICAL INSURANCE
After the Medicare PART B Deductible, we will pay the Medicare PART B coinsurance amount (or, in the case of hospital outpatient department services, the copayment amount) for eligible expenses approved but not paid for by Medicare.

SECTION 3

DEFINITIONS

A BENEFIT PERIOD starts the first time a covered person enters a hospital on or after the date of issue. A new benefit period starts the next time that covered person enters a hospital after being out of a hospital and skilled nursing facility for 60 days in a row (including the day of discharge). There is no limit to the number of benefit periods allowed.

A CALENDAR YEAR begins January 1, and ends December 31, each year.

COVERED PERSON means you, as the Insured and your spouse (husband or wife), if named on the Validation of Coverage Page. You may remove your spouse from coverage at any time by instructing us in writing. A covered person is covered for life so long as this policy is in force.

ELIGIBLE EXPENSES are health care expenses of the kinds covered by Medicare, to the extent considered reasonable and medically necessary as set by Medicare.

A HOSPITAL is an institution which meets Medicare's definition of a hospital.

AN INJURY means accidental bodily injury which occurs while this policy is in force.

MEDICARE means Title XVIII (Health Insurance for the Aged) of the Social Security Act as added by the Social Security Amendments of 1965 as then constituted or later amended.

MEDICAID means the "Health Insurance for the Aged Act", Title XIX of the Social Security Amendments of 1965, as amended.

PHYSICIAN is a doctor meeting Medicare's definition of physician.

A SICKNESS of a covered person means a condition, a state of ill health, or an illness, first manifested by a covered person while this policy is in force on a covered person.

TOTALLY DISABLED means an injury or sickness which results in a covered person's complete inability to:

(A) engage in any employment or occupation for which the covered person, if employed, is qualified by reason of education, training, or experience and be under the continuous care of a doctor; and

(B) perform activities normally performed by persons of the same age and sex in good health.

SECTION 4

PREMIUMS

PREMIUM PAYMENT
The premium must be paid on or before the date it is due or during the grace period.

GRACE PERIOD
The grace period is the 31 days from the date the premium is due. This policy stays in force during the grace period.

PREMIUM CHANGE
We may change the premium table for this policy. Any change may only be made on a policy renewal date. Such change shall be made for all policies with this form number in a class as determined by us. Class means a group of covered persons sharing common attributes affecting premium rates such as, but not limited to area of residence and policy form. No premium change may be made on an individual basis.

LAPSE
This policy will go out of force if the premium is not paid by the end of the grace period.

REINSTATEMENT
If this policy should lapse, we (the Company or an agent we specifically authorize to accept premiums) may accept your premium without having you apply to reinstate this policy. Your premium payment will then put this policy back in force. If we require you to complete an application to reinstate this policy, we will give you a conditional receipt for your payment. This policy will be reinstated when we approve your application. Your policy will be reinstated if you have not received notice in writing from us that the application is not approved within 45 days from the date of such conditional receipt.

If this policy is reinstated, it will pay for only those injuries which occur after the reinstatement date. It will pay for only those sicknesses that are first manifested more than 10 days after the reinstatement date. All other rights of ours or yours will be the same as they were before this policy lapsed. If we reinstate this policy, your payment may be used to pay the premium for a period of time for which the premium had not been paid.

SECTION 5

RIGHT TO BENEFITS

CONTROL OF POLICY

As the Insured, only you are entitled to the policy benefits and to exercise any rights granted under this policy.

SECTION 6

HOW TO FILE A CLAIM

NOTICE OF CLAIM

We must be notified of a claim for benefits within 60 days after you have had an injury or sickness for which you are presenting a claim, or as soon as is reasonably possible. You may give us the notice, or you can have someone give it for you. The notice should give your name and either your policy number or identification number. The notice should be sent to us at our National Headquarters, Omaha, Nebraska, or to any of our agents.

CLAIM FORMS

When we receive your notice of claim for benefits, we will send you any necessary forms to complete. If these forms are not sent to you in 15 days, you will have met the requirements of your proof of claim, if you notify us in writing about the expenses for which you are making a claim for benefits within 90 days after the expenses were incurred.

PROOF OF YOUR CLAIM

We must have proof of all expenses you have incurred for which you are claiming benefits. This proof must reach us within 90 days after you have incurred the expense, or, if this is not possible, as soon as is reasonably possible. Your proof must, however, be given us within 1 year after the time proof is otherwise required, unless you are not legally competent to act.

SECTION 7

PAYMENT OF CLAIMS

Benefits will be paid to you or to whom you assign them in writing. If you are no longer living and had not assigned the benefits, they will be paid to your estate. We will pay the benefits immediately upon receipt of due written proof of your claim. We will honor an assignment of benefits filed at our National Headquarters. We do not assume any responsibility for the validity of an assignment.

SUBROGATION

We shall be subrogated to all rights of recovery which any covered person may have against another party or insurer (including an uninsured or underinsured motorist carrier or workers' compensation) for all benefits paid by us which were incurred by the covered person as a result of acts or omissions of a third party to or on behalf of the covered person for which a third party or insurer is or may be responsible to the extent allowed by law. Medicare claims or liens take priority. Following Medicare, our right to repayment shall be a first priority lien against any recovery by the covered person and is to be paid regardless if the covered person is fully compensated. Our right to repayment is enforceable, regardless if the recovery is by judgment, settlement or otherwise, and regardless of how the recovery proceeds are allocated. The amount of any repayment will be no more than the total amount of benefits paid by us to the covered person, but no more than the amount paid by the other party. No attorney fees may be deducted, unless prior written approval is obtained from us. The covered person agrees to provide us with all necessary and requested information, and to complete all documents required by us to assist us in the enforcement of our right of subrogation recovery.

SECTION 8

GENERAL PROVISIONS

ENTIRE CONTRACT; CHANGES
This policy and any attachments are the entire contract. No agent may change it in any way. Only an executive officer of the Company may make a change and the change must appear in writing as a part of this policy.

CONTINUED COVERAGE
Should you die, your covered spouse will become the Insured.

If you and your covered spouse are divorced, you may both continue your insurance. Either you or your covered spouse may have a separate policy with benefits similar to those contained in this policy. The request for the new policy must be made within 31 days after you or your covered spouse are removed from this policy.

If a covered person incurs eligible expenses for a continuous loss for a covered sickness or injury which occurred prior to the end of such covered person's coverage under this policy, we will pay the benefits for any such loss while the covered person is totally disabled until we have paid benefits to the benefit limit.

SUSPENSION OF COVERAGE
If a covered person applies for and becomes entitled to receive assistance under Medicaid, that person may request us to suspend the benefits and premiums of this policy for up to 24 months in a row. We must be given due proof within 90 days after the date of such entitlement. If, during such 24 month period the entitlement ends, the benefits of this policy will be automatically reinstated as if no suspension had occurred; but only if we are given proof of the loss of such entitlement within 90 days of the loss and all premiums due after the end of the suspension period are paid.

TIME LIMIT ON CERTAIN DEFENSES
We will not void this policy or deny a claim for loss for any expenses incurred after 2 years from the effective date of coverage because of misstatements, except for fraudulent misstatements, made in the application.

PHYSICAL EXAMINATION
We have the right to require that any covered person have a physical examination as often as it may be reasonably necessary to prove a claim. We will pay for any physical examination we require.

LEGAL ACTIONS
You must wait for at least 60 days after you have given us due proof of any claim for benefits in writing before you can bring a legal action to recover under this policy. You have 3 years after the date proof of claim for benefits is required to bring a legal action.

OTHER INSURANCE WITH THIS COMPANY
The insurance in force at any one time on a covered person under a policy or policies with us specifically supplementing any Part of Medicare (Parts A and/or B) will be limited to the policy with the greatest benefit. The premium for any such excess insurance will be returned.

PREMIUM REFUND

If a covered person dies, we will refund any unearned premium. Unearned premium means that part of any premium paid beyond the month in which a covered person dies.

CONFORMITY WITH STATE LAWS

If this policy does not comply with the laws of the state where you live on the date of issue we will treat it as if it had been amended to comply.

MISSTATEMENT OF AGE

If the age of any covered person is misstated, the benefits will be what the premium paid would have bought at the correct age.

ANNUAL MEETING INFORMATION

The annual meeting of the members of American Enterprise Mutual Holding Company shall be held at the principal office of the Corporation at nine o'clock a.m. on the first Tuesday in March of each year for the election of a director or directors and the transaction of any other business properly coming before the annual meeting. At every annual meeting, each member of the Corporation who is a member as of the record date fixed by the board of directors, which shall not be more than 90 days prior to the date of the meeting, shall have one vote upon any proposition coming before such meeting, which vote may only be cast in person or by ballot furnished by the Corporation. In order to vote by ballot, a member as of the record date must request a ballot from the Secretary of the Corporation at least 15 days prior to the annual meeting.

American Republic Corp
Insurance Company P.O. Box 2780, Omaha, NE 68103-2780

MEDICARE SUPPLEMENT INSURANCE POLICY

Notice to Buyer: This policy may not cover all of your medical expenses.

This policy contains an annual high deductible as shown on the Validation of Coverage.
The deductible will be adjusted for inflation each calendar year.

This is a Non Participating Policy.

American Republic Corp Insurance Company and its agents are in no way connected with Medicare.

American Republic Corp Insurance Company is a stock insurance company. We will pay the benefits of this policy under its terms, for injury occurring or sickness first manifested while it is in force. This policy is issued based upon the statements in the attached copy of the application and the payment of the first premium in advance of the date of issue.

30 DAY RIGHT TO EXAMINE POLICY

Please read this policy and the attached application carefully. If you are not satisfied with it for any reason, you may return it to us, or to the agent who took your application, together with a request for cancellation within 30 days after you receive it. You will be sent a full refund of any premium paid. Then the policy will be void from the beginning as if no policy had been issued.

GUARANTEED RENEWAL FOR LIFE

We will renew this policy for any covered person for life. We will renew this policy each time we receive the correct premium before the end of the grace period. While this period is in force, we can't change its benefits without your consent, except as provided for in the BENEFITS Section. The term of coverage under this policy begins at 12:01 a.m. Standard Time, on the date of issue as shown on the Validation of Coverage Page at the place where you reside. It ends at the same time on renewal date shown on the Validation of Coverage Page. Each time this policy is renewed, a new term begins.

In witness whereof, American Republic Corp Insurance Company has caused this policy to be signed by its Executive Officers on the date of issue.

Michael E Abbott — President
Mary K Durand — Secretary
Paul K Mikkelsen — Countersignature

MEDICARE SUPPLEMENT POLICY HIGH DEDUCTIBLE PLAN F
Guaranteed Renewal for Life
The Company Can Change the Premium Rates by Class
Premiums May Change Because of an Increase in Age
Change of Residence, or as Medicare Benefits change

TABLE OF CONTENTS

VALIDATION OF COVERAGE

COVERED PERSON (S):
[John A. Doe, age 65, the Insured]

POLICY NUMBER: [12345678]

DATE OF ISSUE: [NOVEMBER 1, 2008]

FIRST RENEWAL DATE: [varies, based on premium mode selected]

INITIAL PREMIUM AND FEES (if applicable): $ [####]

Annual High Deductible: [$1900.00]

This deductible will be adjusted for inflation each calendar year.

When we use “we” or “us” or “our”, we mean American Republic Corp Insurance Company, and when we use “you” or “your”, we mean the Insured.

SECTION 1

GUARANTEED RENEWAL FOR LIFE

We will renew this policy for any covered person for life. We will renew this policy each time we receive the correct premium before the end of the grace period.

While this policy is in force, we can’t change its benefits without your consent, except as provided for in Section 2. The term of coverage under this policy begins at 12:01 a.m., Standard Time, on the date of issue as shown on the Validation of Coverage Page at the place where you reside. It ends the same time on the renewal date as shown on the Validation of Coverage Page. Each time this policy is renewed, a new term begins.

SECTION 2

BENEFITS

We will pay a covered person’s eligible expenses listed below that are approved but not paid for by Medicare (PART A) Hospital Insurance and Medicare (PART B) Medical Insurance after the covered person has satisfied their Annual High Deductible each Calendar Year. In determining benefits to be paid, we will consider the covered person to be enrolled in and eligible for Medicare Parts A and B. The eligible expenses must be incurred during the benefit period while this policy is in force. The eligible expense must be medically necessary and reasonable as set by Medicare and must result from an injury or sickness unless specifically provided. Benefits will be changed automatically to coincide with any change in the Medicare deductibles and coinsurance amounts.

PART 1 BASIC (CORE) PLAN BENEFITS

(1) MEDICARE PART A HOSPITAL SERVICES AND SUPPLIES EXPENSES

(A) Medicare PART A eligible expenses for hospitalization from the 61st to the 90th day in any Medicare benefit period;

(B) Medicare PART A eligible expenses for hospitalization for each Medicare lifetime inpatient reserve day used; and

(C) When all Medicare hospital inpatient coverage and lifetime reserve days are used up, we will pay 100% of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum of an additional 365 days. The provider shall accept the issuer’s payment as payment in full and may not bill the covered person for any balance.

(2) MEDICARE PART A AND PART B BLOOD DEDUCTIBLES
Coverage under Medicare PARTS A and B for the first three pints of blood (whole blood or units of packed red blood cells) unless replaced in accordance with federal regulations.

(3) MEDICARE PART B MEDICAL INSURANCE
After the Medicare PART B Deductible, we will pay the Medicare PART B coinsurance amount (or, in the case of hospital outpatient department services, the copayment amount) for eligible expenses approved but not paid for by Medicare.

PART 2 ADDITIONAL BENEFITS – PLAN F

(1) MEDICARE (PART A) HOSPITAL INSURANCE DEDUCTIBLE

We will pay the Medicare (PART A) Initial Hospital Insurance Deductible.

(2) SKILLED NURSING FACILITY EXPENSES

We will pay the actual billed charge up to the Medicare daily coinsurance charge (deductible) for days 21 through 100 of a Medicare approved skilled nursing facility stay.

(3) MEDICARE (PART B) MEDICAL INSURANCE DEDUCTIBLE

We will pay the Medicare (PART B) Medical Insurance Deductible.

(4) 100% MEDICARE PART B EXCESS CHARGES

We will pay up to 100% of the excess charge for eligible expenses approved but not paid by Medicare. Excess charge is the difference between the actual billed amount, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved PART B coverage.

(5) MEDICALLY NECESSARY EMERGENCY CARE IN A FOREIGN COUNTRY

We will provide coverage to the extent not covered by Medicare for eighty percent (80%) of billed charges for Medicare-eligible for medically necessary emergency hospital, physician and medical care received in a foreign country. Benefits will be paid if the care would have been covered by Medicare if provided in the United States. Such care must begin during the first sixty (60) consecutive days of each trip outside the United States subject to a calendar year deductible of two hundred fifty dollars ($250), and a lifetime maximum of fifty thousand dollars ($50,000).

Emergency Care means care needed immediately because of an injury or an illness of sudden and unexpected onset.

SECTION 3

DEFINITIONS

ANNUAL HIGH DEDUCTIBLE means the amount the covered person must satisfy each Calendar Year before we begin paying benefits under this contract. The annual high deductible includes out-of-pocket expenses, other than premiums, for service covered as benefits under this policy and shall be in addition to any other specific benefit deductibles. Expenses incurred before the effective date of this coverage will not be applied to this deductible.

A BENEFIT PERIOD starts the first time a covered person enters a hospital on or after the date of issue. A new benefit period starts the next time that covered person enters a hospital after being out of a hospital and skilled nursing facility, for 60 days in a row (including the day of discharge). There is no limit to the number of benefit periods allowed.

A CALENDAR YEAR begins January 1, and ends December 31, each year.

COVERED PERSON means you, as the Insured and your spouse (husband or wife), if named on page 1. You may remove your spouse from coverage at any time by instructing us in writing. A covered person is covered for life so long as this policy is in force.

ELIGIBLE EXPENSES are health care expenses of the kinds covered by Medicare, to the extent considered reasonable and medically necessary as set by Medicare.

A HOSPITAL is an institution which meets Medicare's definition of a hospital.

AN INJURY means accidental bodily injury which occurs while this policy is in force.

MEDICARE means Title XVIII (Health Insurance for the Aged) of the Social Security Act as added by the Social Security Amendments of 1965 as then constituted or later amended.

MEDICAID means the "Health Insurance for the Aged Act", Title XIX of the Social Security Amendments of 1965, as amended.

PHYSICIAN is a doctor meeting Medicare's definition of physician.

A SICKNESS of a covered person means a condition; a state if ill health, or an illness first manifested by a covered person while this policy is in force on a covered person.

TOTALLY DISABLED means an injury or sickness which results in a covered person's complete inability to:

(A) engage in any employment or occupation for which the covered person, if employed, is qualified by reason of education, training, or experience and be under the continuous care of a doctor; and

(B) perform activities normally performed by persons of the same age and sex in good health.

SECTION 4

PREMIUMS

Premium Payment
The premium must be paid on or before the date it is due or during the grace period.

Grace Period
The grace period is the 31 days from the date the premium is due. This policy stays in force during the grace period.

Premium Change
We may change the premium table for this policy. Any change may only be made on a policy renewal date. Such change shall be made for all policies with this form number in a class as determined by us. Class means a group of covered persons sharing common attributes affecting premium rates such as, but not limited to area of residence and policy form. No premium change may be made on an individual basis.

Lapse
This policy will go out of force if the premium is not paid by the end of the grace period.

Reinstatement
If this policy should lapse, we (the Company or an agent we specifically authorize the accept premiums) may accept your premium without having you apply to reinstate this policy. Your premium payment will then put this policy back in force. If we require you to complete an application to reinstate this policy, we will give you a conditional receipt for your payment. This policy will be reinstated when we approve your application. Your policy will be reinstated if you have not received notice in writing from us that the application is not approved within 45 days from the date of such conditional receipt.

If this policy is reinstated, it will pay for only those injuries which occur after the reinstatement date. It will pay for only those sicknesses that are first manifested more than 10 days after the reinstatement date. All other rights of ours or yours will be the same as they were before this policy lapsed. If we reinstate this policy, your payment may be used to pay the premium for a period of time for which the premium had not been paid.

SECTION 5

RIGHT TO BENEFITS

Control of Policy
As the insured, only you are entitled to the policy benefits and to exercise any rights granted under this policy.

SECTION 6

HOW TO FILE A CLAIM

Notice of Claim
We must be notified of a claim for benefits within 60 days after you have had an injury or sickness for which you are presenting a claim, or as soon as is reasonably possible. You may give us the notice, or you can have someone give it for you. The notice should give your name and either your policy number or identification number. The notice should be sent to us at our National Headquarters, Omaha, Nebraska, or to any of our agents.

Claim Forms
When we receive your notice of claim for benefits, we will send you any necessary forms to complete. If these forms are not sent to you in 15 days, you will have met the requirements of your proof of claim, if you notify us in writing about the expenses for your which you are making a claim for benefits within 90 days after the expenses were incurred.

Proof of your Claim
We must have proof of all expenses you have incurred for which you are claiming benefits. This proof must reach us within 90 days after you have incurred the expense, or, if this is not possible, as soon as is reasonably possible. Your proof must, however, be given us within 1 year after the time proof is otherwise required, unless you are not legally competent to act.

SECTION 7

PAYMENT OF CLAIMS

Benefits will be paid to you or to whom you assign them in writing. If you are no longer living and had not assigned the benefit, they will be paid to your estate. We will pay the benefits immediately upon receipt of due written proof of your claim. We will honor an assignment of benefits filed at our National Headquarters. We do not assume any responsibility for the validity of an assignment.

Subrogation
We shall be subrogated to all rights of recovery which any covered person may have against another party or insurer (including an uninsured or underinsured motorist carrier or workers' compensation) for all benefits paid by us which were incurred by the covered person as a result of acts or omissions of a third party to or on behalf of the covered person for which a third party or insurer is or may be responsible to the extent allowed by law. Medicare claims or liens take priority. Following Medicare, our right to repayment shall be a first priority lien again any recovery by the covered person and is to be paid regardless if the covered person is fully compensated. Our right to repayment is enforceable, regardless if the recovery is by judgment, settlement or otherwise, and regardless of how the recovery proceeds are allocated. The amount of any repayment will be no more than the total amount of benefits paid by us to the covered person, but no more than the amount paid by the other party. No attorney fees may be deducted, unless prior written approval is obtained from us. The covered person agrees to provide us with all necessary and requested information, and to complete all documents required by us to assist us in the enforcement of our right of subrogation recovery.

SECTION 8

GENERAL PROVISIONS

Entire Contract; Changes
This policy and any attachments are the entire contract. No agent may change it in any way. Only an executive officer of the Company may make a change and the change must appear in writing as a part of this policy.

Continued Coverage
Should you die, your covered spouse will become the Insured.

If you and your covered spouse are divorced, you may both continue your insurance. Either you or your covered spouse may have a separate policy with benefits similar to those contained in this policy. The request for the new policy must be made within 31 days after you or your covered spouse are removed from this policy.

If a covered person incurs eligible expenses for a continuous loss for a covered sickness or injury which occurred prior to the end of such covered person's coverage under this policy, we will pay the benefits for any such loss while the covered person is totally disabled until we have paid benefits to the benefit limit.

Suspension of Coverage
If a covered person applies for and becomes entitled to receive assistance under Medicaid, that person may request us to suspend the benefits and premiums of this policy for up to 24 months in a row. We must be given due proof within 90 days after the date of such entitlement. If, during such 24 month period the entitlement ends, the benefits of this policy will be automatically reinstated as if no suspension had occurred; but only if we are given proof of the loss of such entitlement within 90 days of the loss and all premiums due after the end of the suspension period are paid.

Time Limit on Certain Defenses
We will not void this policy or deny a claim for loss for any expenses incurred after 2 years from the effective date of coverage because of misstatements, except for fraudulent misstatements, made in the application.

Physical Examination
We have the right to require that any covered person have a physical examination as often as it may be reasonably necessary to prove a claim. We will pay for any physical examination we require.

Legal Actions
You must wait for at least 60 days after you have given us due proof of any claim for benefits in writing before you can bring a legal action to recover under this policy. You have 3 years after the date proof of claim for benefits is required to bring legal action.

Other Insurance with this Company
The insurance in force at any one time on a covered person under a policy or policies with us specifically supplementing any Part of Medicare (Parts A and/or B) will be limited to the policy with the greatest benefit. The premium for any such excess insurance will be returned.

PREMIUM REFUND
If a covered person dies, we will refund any unearned premium. Unearned premium means that part of any premium paid beyond the month in which a covered person dies.

Conformity with State Laws
If this policy does not comply with the laws of the state where you live on the date of issue we will treat it as if it had been amended to comply.

Misstatement of Age
If the age of any covered person is misstated, the benefits will be what the premium paid would have bought at the correct age.

Annual Meeting Information
The annual meeting oaf the members of American Enterprise Mutual Holding Company shall be held at the principal office of the Corporation at nine o'clock a.m. on the first Tuesday in March of each year for the election of a director or directors and the transaction of any other business properly coming before the annual meeting. At every annual meeting, each member of the Corporation who is a member as of the record date fixed by the board of directors, which shall not be more than 90 days prior to the date of the meeting, shall have one vote upon any proposition coming before such meeting, which vote may only be cast in person or by ballot furnished by the Corporation. In order to vote by ballot, a member as of the record date must request a ballot from the Secretary of the Corporation at least 15 days prior to the annual meeting.

American Republic Corp
Insurance Company P.O. Box 2780, Omaha, NE 68103-2780

MEDICARE SUPPLEMENT INSURANCE POLICY

Notice to Buyer: This policy may not cover all of your medical expenses.

American Republic Corp Insurance Company and its agents are in no way connected with Medicare.

This is a Non Participating Policy.

American Republic Corp Insurance Company is a stock insurance company. We will pay the benefits of this policy under its terms, for injury occurring or sickness first manifested while it is in force. This policy is issued based upon the statements in the attached copy of the application and the payment of the first premium in advance of the date of issue.

30 DAY RIGHT TO EXAMINE POLICY

Please read this policy and the attached application carefully. If you are not satisfied with it for any reason, you may return it to us, or to the agent who took your application, together with a request for cancellation within 30 days after you receive it. You will be sent a full refund of any premium paid. Then the policy will be void from the beginning as if no policy had been issued.

GUARANTEED RENEWAL FOR LIFE

We will renew this policy for any covered person for life. We will renew this policy each time we receive the correct premium before the end of the grace period. While this policy is in force, we can't change its benefits without your consent, except as provided for in the BENEFITS Section. The term of coverage under this policy begins at 12:01 a.m., Standard Time, on the issue date as shown on the Validation of Coverage Page at the place where you reside. It ends at the same time on renewal date as shown on the Validation of Coverage Page. Each time this policy is renewed, a new term begins.

In witness whereof, American Republic Corp Insurance Company has caused this policy to be signed by its Executive Officers on the date of issue.

Michael E Abbott — President
Mary K Durand — Secretary
Paul K Mikkelsen — Countersignature

MEDICARE SUPPLEMENT POLICY PLAN J
Guaranteed Renewable For Life
The Company Can Change The Premium Rates By Class
Premiums May Change Because of A Change
Of Residence, Or As Medicare Benefits Change

TABLE OF CONTENTS

VALIDATION OF COVERAGE

COVERED PERSON (S): [John A. Doe, age 65, the Insured]

POLICY NUMBER: [12345678]

DATE OF ISSUE: [NOVEMBER 1, 2008]

FIRST RENEWAL DATE: [varies, based on premium mode selected]

INITIAL PREMIUM AND FEES (if applicable): $ [####]

When we use "we" or "us" or "our," we mean American Republic Corp Insurance Company, and when we use "you" or "your," we mean the Insured.

SECTION 1

GUARANTEED RENEWAL FOR LIFE

We will renew this policy for any covered person for life. We will renew this policy each time we receive the correct premium before the end of the grace period.

While this policy is in force, we can't change its benefits without your consent, except as provided for in Section 2. The term of coverage under this policy begins at 12:01 a.m., Standard Time, on the issue date as shown on the Validation of Coverage Page at the place where you reside. It ends at the same time on the renewal date as shown on the Validation of Coverage Page. Each time this policy is renewed, a new term begins.

SECTION 2

BENEFITS

We will pay a covered person's eligible expenses listed below that are approved but not paid for by Medicare (PART A) Hospital Insurance and Medicare (PART B) Medical Insurance. In determining benefits to be paid, we will consider the covered person to be enrolled in and eligible for Medicare Parts A and B. The eligible expenses must be incurred during the benefit period while this policy is in force. The eligible expense must be medically necessary and reasonable as set by Medicare and must result from an injury or sickness unless specifically provided. Benefits will be changed automatically to coincide with any change in the Medicare deductibles and coinsurance amounts.

PART 1 BASIC (CORE) PLAN BENEFITS

(1) MEDICARE PART A HOSPITAL SERVICES AND SUPPLIES EXPENSES

(A) Medicare PART A eligible expenses for hospitalization from the 61st to the 90th day in any Medicare benefit period;

(B) Medicare PART A eligible expenses for hospitalization for each Medicare lifetime inpatient reserve day used; and

(C) When all Medicare hospital inpatient coverage and lifetime reserve days are used up we will pay 100% of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the covered person for any balance.

(2) MEDICARE PART A AND PART B BLOOD DEDUCTIBLES
Coverage under Medicare PARTS A and B for the first three pints of blood (whole blood or units of packed red blood cells) unless replaced in accordance with federal regulations.

(3) MEDICARE PART B MEDICAL INSURANCE
After the Medicare PART B Deductible, we will pay the Medicare PART B coinsurance amount (or, in the case of hospital outpatient department services, the copayment amount) for eligible expenses approved but not paid for by Medicare.

PART 2 ADDITIONAL BENEFITS – PLAN J

(1) MEDICARE (PART A) HOSPITAL INSURANCE DEDUCTIBLE
We will pay the Medicare (PART A) Initial Hospital Insurance Deductible.

(2) SKILLED NURSING FACILITY EXPENSES
We will pay the actual billed charge up to the Medicare daily coinsurance charge (deductible) for days 21 through 100 of a Medicare approved skilled nursing facility stay.

(3) MEDICARE (PART B) MEDICAL INSURANCE DEDUCTIBLE
We will pay the Medicare (PART B) Medical Insurance Deductible.

(4) 100% MEDICARE PART B EXCESS CHARGES
We will pay up to 100% of the excess charge for eligible expenses approved but not paid by Medicare. Excess charge is the difference between the actual billed amount, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved PART B charge.

(5) MEDICALLY NECESSARY EMERGENCY CARE IN A FOREIGN COUNTRY
We will provide coverage to the extent not covered by Medicare for eighty percent (80%) of billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician and medical care received in a foreign country. Benefits will be paid if the care would have been covered by Medicare if provided in the United States. Such care must begin during the first sixty (60) consecutive days of each trip outside the United States subject to a calendar year deductible of two hundred fifty dollars ($250), and a lifetime maximum of fifty thousand dollars ($50,000).

Emergency Care means care needed immediately because of an injury or an illness of sudden and unexpected onset.

(6) PREVENTIVE MEDICAL CARE
We will pay the actual charge up to one hundred percent (100%) of the Medicare approved amount for each service, as if Medicare covered the service as identified by the American Medical Association Current Procedural Terminology (AMA CPT) for the following preventive health services. This benefit is subject to a calendar year maximum of $120.00.

(A) An annual clinical preventive medical history and physical examination that may include tests and services described in (B) and patient education to address preventive health care measures; and

(B) Preventive screening tests or preventive services, the selection and frequency that is determined to be medically appropriate by your doctor.

This benefit shall not include payment for any procedure covered by Medicare.

(7) AT-HOME RECOVERY BENEFIT

We will pay for services to provide short term, at-home assistance with activities of daily living for those recovering from an illness, injury or surgery. At-home recovery must be primarily services which assist in activities of daily living. The insured's attending physician must certify that the specific type and frequency of at-home recovery services are necessary because of a condition for which a home health care plan of treatment was approved by Medicare.

Coverage is limited to:

(A) no more than the number and type of at-home recovery visits certified as necessary by the insured's attending physician. The total number of at-home recovery visits shall not exceed the number of Medicare approved home health care visits under a Medicare approved Home Care Plan of Treatment;

(B) the actual charges for each visit up to a maximum reimbursement of forty dollars ($40) per visit;

(C) one thousand six hundred dollars ($1600) per calendar year;

(D) seven (7) visits in any one week;

(E) care furnished on a visiting basis in the insured's home;

(F) services provided by a care provider as defined in this section;

(G) at-home recovery visits while the insured is covered under the policy and not otherwise excluded;

(H) at-home recovery visits received during the period the insured is receiving Medicare approved home care services or no more than eight (8) weeks after the service date of the last Medicare approved home health care visit.

We will not pay for Home care visits paid for by Medicare or any other government programs, care provided by family members, unpaid volunteers or providers who are not care providers.

ACTIVITIES OF DAILY LIVING include, but are not limited to bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally self-administered, and changing bandages or other dressings.

CARE PROVIDER means a duly licensed home health aide/homemaker, personal care aide or nurse provided through a licensed home health care agency or referred by a licensed referral agency or licensed nurses registry.

HOME shall mean any place used by the insured as a place of residence, provided that such place would qualify as a residence for home health care services covered by Medicare. A hospital or skilled nursing facility shall not be considered the insured's place of residence.

AT-HOME RECOVERY VISIT means the period of a visit required to provide at home recovery care, without limit on the duration of the visit, except each consecutive four (4) hours in a twenty-four (24) hour period of services provided by a care provider is one visit.

SECTION 3

DEFINITIONS

A BENEFIT PERIOD starts the first time a covered person enters a hospital on or after the date of issue. A new benefit period starts the next time that covered person enters a hospital after being out of a hospital and skilled nursing facility for 60 days in a row (including the day of discharge). There is no limit to the number of benefit periods allowed.

A CALENDAR YEAR begins January 1, and ends December 31, each year.

COVERED PERSON means you, as the Insured and your spouse (husband or wife), if named on the Validation of Coverage Page. You may remove your spouse from coverage at any time by instructing us in writing. A covered person is covered for life so long as this policy is in force.

ELIGIBLE EXPENSES are health care expenses of the kinds covered by Medicare, to the extent considered reasonable and medically necessary as set by Medicare.

A HOSPITAL is an institution which meets Medicare's definition of a hospital.

AN INJURY means accidental bodily injury which occurs while this policy is in force.

MEDICARE means Title XVIII (Health Insurance for the Aged) of the Social Security Act as added by the Social Security Amendments of 1965 as then constituted or later amended.

MEDICAID means the "Health Insurance for the Aged Act", Title XIX of the Social Security Amendments of 1965, as amended.

PHYSICIAN is a doctor meeting Medicare's definition of physician.

A SICKNESS of a covered person means a condition, a state of ill health, or an illness, first manifested by a covered person while this policy is in force on a covered person.

TOTALLY DISABLED means an injury or sickness which results in a covered person's complete inability to:

(A) engage in any employment or occupation for which the covered person, if employed, is qualified by reason of education, training, or experience and be under the continuous care of a doctor; and

(B) perform activities normally performed by persons of the same age and sex in good health.

SECTION 4

PREMIUMS

PREMIUM PAYMENT
The premium must be paid on or before the date it is due or during the grace period.

GRACE PERIOD
The grace period is the 31 days from the date the premium is due. This policy stays in force during the grace period.

PREMIUM CHANGE
We may change the premium table for this policy. Any change may only be made on a policy renewal date. Such change shall be made for all policies with this form number in a class as determined by us. Class means a group of covered persons sharing common attributes affecting premium rates such as, but not limited to area of residence and policy form. No premium change may be made on an individual basis.

LAPSE
This policy will go out of force if the premium is not paid by the end of the grace period.

REINSTATEMENT
If this policy should lapse, we (the Company or an agent we specifically authorize to accept premiums) may accept your premium without having you apply to reinstate this policy. Your premium payment will then put this policy back in force. If we require you to complete an application to reinstate this policy, we will give you a conditional receipt for your payment. This policy will be reinstated when we approve your application. Your policy will be reinstated if you have not received notice in writing from us that the application is not approved within 45 days from the date of such conditional receipt.

If this policy is reinstated, it will pay for only those injuries which occur after the reinstatement date. It will pay for only those sicknesses that are first manifested more than 10 days after the reinstatement date. All other rights of ours or yours will be the same as they were before this policy lapsed. If we reinstate this policy, your payment may be used to pay the premium for a period of time for which the premium had not been paid.

SECTION 5

RIGHT TO BENEFITS

CONTROL OF POLICY
As the Insured, only you are entitled to the policy benefits and to exercise any rights granted under this policy.

SECTION 6

HOW TO FILE A CLAIM

NOTICE OF CLAIM
We must be notified of a claim for benefits within 60 days after you have had an injury or sickness for which you are presenting a claim, or as soon as is reasonably possible. You may give us the notice, or you can have someone give it for you. The notice should give your name and either your policy number or identification number. The notice should be sent to us at our National Headquarters, Omaha, Nebraska, or to any of our agents.

CLAIM FORMS
When we receive your notice of claim for benefits, we will send you any necessary forms to complete. If these forms are not sent to you in 15 days, you will have met the requirements of your proof of claim, if you notify us in writing about the expenses for which you are making a claim for benefits within 90 days after the expenses were incurred.

PROOF OF YOUR CLAIM
We must have proof of all expenses you have incurred for which you are claiming benefits. This proof must

reach us within 90 days after you have incurred the expense, or, if this is not possible, as soon as is reasonably possible. Your proof must, however, be given us within 1 year after the time proof is otherwise required, unless you are not legally competent to act.

SECTION 7

PAYMENT OF CLAIMS

Benefits will be paid to you or to whom you assign them in writing. If you are no longer living and had not assigned the benefits, they will be paid to your estate. We will pay the benefits immediately upon receipt of due written proof of your claim. We will honor an assignment of benefits filed at our National Headquarters. We do not assume any responsibility for the validity of an assignment.

SUBROGATION

We shall be subrogated to all rights of recovery which any covered person may have against another party or insurer (including an uninsured or underinsured motorist carrier or workers' compensation) for all benefits paid by us which were incurred by the covered person as a result of acts or omissions of a third party to or on behalf of the covered person for which a third party or insurer is or may be responsible to the extent allowed by law. Medicare claims or liens take priority. Following Medicare, our right to repayment shall be a first priority lien against any recovery by the covered person and is to be paid regardless if the covered person is fully compensated. Our right to repayment is enforceable, regardless if the recovery is by judgment, settlement or otherwise, and regardless of how the recovery proceeds are allocated. The amount of any repayment will be no more than the total amount of benefits paid by us to the covered person, but no more than the amount paid by the other party. No attorney fees may be deducted, unless prior written approval is obtained from us. The covered person agrees to provide us with all necessary and requested information, and to complete all documents required by us to assist us in the enforcement of our right of subrogation recovery.

SECTION 8

GENERAL PROVISIONS

ENTIRE CONTRACT; CHANGES

This policy and any attachments are the entire contract. No agent may change it in any way. Only an executive officer of the Company may make a change and the change must appear in writing as a part of this policy.

CONTINUED COVERAGE

Should you die, your covered spouse will become the Insured.

If you and your covered spouse are divorced, you may both continue your insurance. Either you or your covered spouse may have a separate policy with benefits similar to those contained in this policy. The request for the new policy must be made within 31 days after you or your covered spouse are removed from this policy.

If a covered person incurs eligible expenses for a continuous loss for a covered sickness or injury which occurred prior to the end of such covered person's coverage under this policy, we will pay the benefits for any such loss while the covered person is totally disabled until we have paid benefits to the benefit limit.

SUSPENSION OF COVERAGE

If a covered person applies for and becomes entitled to receive assistance under Medicaid, that person may request us to suspend the benefits and premiums of this policy for up to 24 months in a row. We must be given

due proof within 90 days after the date of such entitlement. If, during such 24 month period the entitlement ends, the benefits of this policy will be automatically reinstated as if no suspension had occurred; but only if we are given proof of the loss of such entitlement within 90 days of the loss and all premiums due after the end of the suspension period are paid.

TIME LIMIT ON CERTAIN DEFENSES

We will not void this policy or deny a claim for loss for any expenses incurred after 2 years from the effective date of coverage because of misstatements, except for fraudulent misstatements, made in the application.

PHYSICAL EXAMINATION

We have the right to require that any covered person have a physical examination as often as it may be reasonably necessary to prove a claim. We will pay for any physical examination we require.

LEGAL ACTIONS

You must wait for at least 60 days after you have given us due proof of any claim for benefits in writing before you can bring a legal action to recover under this policy. You have 3 years after the date proof of claim for benefits is required to bring a legal action.

OTHER INSURANCE WITH THIS COMPANY

The insurance in force at any one time on a covered person under a policy or policies with us specifically supplementing any Part of Medicare (Parts A and/or B) will be limited to the policy with the greatest benefit. The premium for any such excess insurance will be returned.

PREMIUM REFUND

If a covered person dies, we will refund any unearned premium. Unearned premium means that part of any premium paid beyond the month in which a covered person dies.

CONFORMITY WITH STATE LAWS

If this policy does not comply with the laws of the state where you live on the issue date we will treat it as if it had been amended to comply.

MISSTATEMENT OF AGE

If the age of any covered person is misstated, the benefits will be what the premium paid would have bought at the correct age.

ANNUAL MEETING INFORMATION

The annual meeting of the members of American Enterprise Mutual Holding Company shall be held at the principal office of the Corporation at nine o'clock a.m. on the first Tuesday in March of each year for the election of a director or directors and the transaction of any other business properly coming before the annual meeting. At every annual meeting, each member of the Corporation who is a member as of the record date fixed by the board of directors, which shall not be more than 90 days prior to the date of the meeting, shall have one vote upon any proposition coming before such meeting, which vote may only be cast in person or by ballot furnished by the Corporation. In order to vote by ballot, a member as of the record date must request a ballot from the Secretary of the Corporation at least 15 days prior to the annual meeting.

SERFF Tracking Number:	*AMRP-125802357*	*State:*	*Arkansas*
Filing Company:	*American Republic Corp Insurance Company*	*State Tracking Number:*	*40245*
Company Tracking Number:	*11AR0508*		
TOI:	*MS05I Individual Medicare Supplement - Standard Plans*	*Sub-TOI:*	*MS05I.001 Plan A*
Product Name:	*Medicare Supplement*		
Project Name/Number:	*/*		

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number:	*AMRP-125802357*	*State:*	*Arkansas*
Filing Company:	*American Republic Corp Insurance Company*	*State Tracking Number:*	*40245*
Company Tracking Number:	*11AR0508*		
TOI:	*MS05I Individual Medicare Supplement - Standard Plans*	*Sub-TOI:*	*MS05I.001 Plan A*
Product Name:	*Medicare Supplement*		
Project Name/Number:	*/*		

Rate/Rule Schedule

Review Status:	Document Name:	Affected Form Numbers: (Separated with commas)	Rate Action:*	Rate ActionInformation:	Attachments
Approved	Rates DTC AR	C-1042AR, C-1043AR, C-1044AR	New		Rates DTC AR.pdf

AMERICAN REPUBLIC CORP INSURANCE COMPANY
Plan: C-1042 2009 Annual Attained Age Rates
ARKANSAS Table

	Standard Single	Standard Couple
64-99	1,445.65	1,280.79

Semi-Annual	=	.5 X Annual
Quarterly	=	.25 X Annual
Monthly Direct	=	.087 X Annual
Monthly PAC	=	.08334 X Annual

Zip Code Area Factors

71700-71799	1.11
71800-71899	1.17
72200-72299	1.29
72300-72599	1.17
72600-72999	1.11
ALL OTHERS	1.23

A factor of 0.85 is applied to all Preferred class policies.

AMERICAN REPUBLIC CORP INSURANCE COMPANY
Plan: C-1043 2009 Annual Attained Age Rates
ARKANSAS Table

	Standard Single	Standard Couple
64-99	1,807.06	1,521.73

Semi-Annual	=	.5 X Annual
Quarterly	=	.25 X Annual
Monthly Direct	=	.087 X Annual
Monthly PAC	=	.08334 X Annual

Zip Code Area Factors

71700-71799	1.11
71800-71899	1.17
72200-72299	1.29
72300-72599	1.17
72600-72999	1.11
ALL OTHERS	1.23

A factor of 0.85 is applied to all Preferred class policies.

AMERICAN REPUBLIC CORP INSURANCE COMPANY
Plan: C-1044 2009 Annual Attained Age Rates
ARKANSAS Table

	Standard Single	Standard Couple
64-99	1,807.06	1,585.14

Semi-Annual	=	.5 X Annual
Quarterly	=	.25 X Annual
Monthly Direct	=	.087 X Annual
Monthly PAC	=	.08334 X Annual

Zip Code Area Factors

71700-71799	1.11
71800-71899	1.17
72200-72299	1.29
72300-72599	1.17
72600-72999	1.11
ALL OTHERS	1.23

A factor of 0.85 is applied to all Preferred class policies.

SERFF Tracking Number:	*AMRP-125802357*	*State:*	*Arkansas*
Filing Company:	*American Republic Corp Insurance Company*	*State Tracking Number:*	*40245*
Company Tracking Number:	*11AR0508*		
TOI:	*MS05I Individual Medicare Supplement - Standard Plans*	*Sub-TOI:*	*MS05I.001 Plan A*
Product Name:	*Medicare Supplement*		
Project Name/Number:	*/*		

Supporting Document Schedules

Review Status:

Satisfied -Name: Certification/Notice — Approved — 11/20/2008

Comments:

Attachment:

Flesch Cert.pdf

Review Status:

Bypassed -Name: Application — Approved — 11/20/2008

Bypass Reason: We will be using application form C-1031 with these products. This application form was filed and approved with your Department on 2/27/2008. Please refer to SERFF Tracking Number: SERFF Tr Num: AMRP-125379102; State Tr Num: 37844; Co Tr Num: 11AR0505.

Comments:

Review Status:

Satisfied -Name: Outline of Coverage — Approved — 11/20/2008

Comments:

Attachment:

C-1042-1.pdf

American Republic Corp
Insurance Company P.O. Box 2780, Omaha, NE 68103-2780

To: Department of Insurance

RE: Forms C-1042AR (Medicare Supplement Plan A), C-1043AR (Medicare Supplement High Deductible Plan F), C-1044AR (Medicare Supplement Plan J) and C-1042-1AR (Outline of Coverage)

I certify the policy form being filed complies with Rule 19, Rule 49 and ACA 23-79-138.

I also certify the forms being filed meet minimum requirements of the Flesch reading ease policy simplification test, and that: the Flesch reading ease test has been applied to each form, and each form reaches a readability score of at least 40. Also the type size is at least 10 point, one point leaded.

Christopher Aasland, FSA, MAAA
Vice President and Actuary

Dated: August 28, 2008

American Republic Corp Insurance Company

P.O. Box 2780, Omaha, NE 68103-2780

Outline of Medicare Supplement Coverage-cover page 1 of 2

Benefit Plan A , F* and J

These charts show the benefits included in each of the standard Medicare Supplement plans. Every company must make available Plan "A". Some plans may not be available in your state.

See Outlines of Coverage sections for details about ALL plans.

BASIC BENEFITS for Plans A-J:

Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.

Medical Expenses: Part B coinsurance (generally 20% of Medicare-approved expenses), or copayments for hospital outpatient services.

Blood: First three pints of blood each year.

A	B	C	D	E	F	F*	G	H	I	J	J*
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits		Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible		Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	
		Part B Deductible			Part B Deductible					Part B Deductible	
					Part B Excess (100%)		Part B Excess (80%)		Part B Excess (100%)	Part B Excess (100%)	
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	
			At-Home Recovery				At-Home Recovery		At-Home Recovery	At-Home Recovery	
				Preventive Care NOT covered by Medicare						Preventive Care NOT covered by Medicare	

* Plans F and J also have an option called a high deductible plan F and a high deductible plan J. These high deductible plans pay the same benefits as Plans F and J after one has paid a calendar-year [$1,900] deductible. Benefits from high deductible Plans F and J will not begin until out-of-pocket expenses are [$1,900]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

American Republic Corp Insurance Company

P.O. Box 2780, Omaha, NE 68103-2780

Outline of Medicare Supplement Coverage-cover page 2 of 2

BASIC BENEFITS for Plans K and L include similar services as plans A-J, but cost-sharing for the basic benefits is at different levels.

J J*	K**	L**
Basic Benefits	100% of Part A Hospitalization Coinsurance plus coverage for 365 days after Medicare benefits end 50% Hospice cost-sharing 50% of Medicare-eligible expenses for the first three pints of blood 50% Part B Coinsurance, except 100% Coinsurance for Part B Preventive Services	100% of Part A Hospitalization Coinsurance plus coverage for 365 Days after Medicare Benefits End 75% Hospice cost-sharing 75% of Medicare-eligible expenses for the first three pints of blood 75% Part B Coinsurance, except 100% Coinsurance for Part B Preventive Services
Skilled Nursing Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance
Part A Deductible	50% Part A Deductible	75% Part A Deductible
Part B Deductible		
Part B Excess (100%)		
Foreign Travel Emergency		
At-Home Recovery		
Preventive Care NOT covered by Medicare		
	[$4,440] Out of Pocket Annual Limit***	[$2,220] Out of Pocket Annual Limit***

** Plans K and L provide for different cost-sharing for items and services than Plans A-J.
Once you reach the annual limit, the plan pays 100% of the Medicare copayments, coinsurance, and deductibles for the rest of the calendar year. The out-of-pocket annual limit does NOT include charges from your provider that exceed Medicare-approved amounts, called “Excess Charges”. You will be responsible for paying excess charges.

***The out-of-pocket annual limit will increase each year for inflation.

See Outlines of Coverage for details and exceptions.

PREMIUM AND RENEWABILITY INFORMATION

This policy is Guaranteed Renewable for Life as long as the premiums are paid on time. Premiums increase because a covered person is one year older. The premium table for this policy may change by class as determined by the Company. Premiums may change because of a change in residence or as Medicare benefits change. We can only raise your premiums if we raise the premiums for all policies like yours in this state. No premium change may be made on an individual basis. You have a 31-day grace period to pay your premium.

Mode Factors: [Monthly Direct Bill: 0.087 Quarterly: 0.25 Semiannual: 0.50 APP: 0.08334]

Applicant's premium at issue age_____(Age) for each plan available on_____(Date) is:

	PLAN A	High Deductible PLAN F	PLAN J
ANNUAL PREMIUMS	$_____	$_____	$_____

Spouse's premium at issue age_____(Age) for each plan available on_____(Date) is: (if applying)

	PLAN A	High Deductible PLAN F	PLAN J
ANNUAL PREMIUMS	$_____	$_____	$_____

DISCLOSURES

Use this outline to compare benefits and premiums between policies.

READ YOUR POLICY VERY CAREFULLY

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all the rights and duties of both you and your insurance company.

RIGHT TO RETURN POLICY

If you find you are not satisfied with your policy, you may return it to American Republic Corp Insurance Company, P.O. Box 2780, Omaha, Nebraska 68103-2780. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

POLICY REPLACEMENT

If you are replacing another health insurance policy do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE

This policy may not fully cover all of your medical costs.

Neither American Republic Corp Insurance Company nor its agents are connected with Medicare.

This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult "Medicare & You" for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The Company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information.

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

American Republic Corp Insurance Company

P.O. Box 2780, Omaha, NE 68103-2780

PLAN A

Medicare (Part A) Hospital Services Per Benefit Period[1]

SERVICES	MEDICARE PAYS	PLAN A PAYS	YOU PAY[2]
HOSPITALIZATION[1] Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [$1,024] (Part A Deductible)	$0	[$ 1,024]
61st thru 90th day	All but [$256] a day	[$256] a day	$0
91st day and after: • While using 60 lifetime reserve days	All but [$512] a day	[$512] a day	$0
• Once lifetime reserve days are used: • Additional 365 days	$0	100% of Medicare eligible expenses	$0[3]
• Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE[1] You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but [$128] a day	$0	Up to [$128] a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

[1] A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

[2] $0 indicates your liability for covered charges. You are responsible for all other noncovered charges.

[3] NOTICE:When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid for Medicare-covered items or services.

PLAN A (continued)

Medicare (Part B) - Medical Services - Per Calendar Year

SERVICES	MEDICARE PAYS	PLAN A PAYS	YOU PAY[2]
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT Such as: Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First [$135] of Medicare-approved amounts[1] (Part B Deductible)	$0	$0	[$135] (Part B Deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (Above Medicare-approved amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next [$135] of Medicare-approved amounts[1] (Part B Deductible)	$0	$0	[$135] (Part B Deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

Medicare (Parts A and B) Hospital and Medical Services

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY[2]
HOME HEALTH CARE- MEDICARE-APPROVED SERVICES			
• Medically necessary skilled care services and medical supplies	100%	$0	$0
• Durable medical equipment			
First [$135] of Medicare-approved amounts[1]	$0	$0	[$135] (Part B Deductible)
Remainder of Medicare-approved amounts	80%	20%	$0

[1] Once you have been billed [$135] of Medicare-approved amounts for covered services, your Part B Deductible will have been met for the calendar year.

[2] $0 indicates your liability for covered charges. You are responsible for all other noncovered charges.

HIGH DEDUCTIBLE PLAN F

Medicare (Part A) - Hospital Services - Per Benefit Period

SERVICES	MEDICARE PAYS	AFTER YOU PAY [$1,900] DEDUCTIBLE,[2] PLAN PAYS	IN ADDITION TO [$1,900] DEDUCTIBLE,[2] YOU PAY[3]
HOSPITALIZATION[1] Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [$1,024]	[$1,024] (Part A Deductible)	$0
61st thru 90th day	All but [$256] a day	[$256] a day	$0
91st day and after: • While using 60 lifetime reserve days	All but [$512] a day	[$512] a day	$0
• Once lifetime reserve days are used: • Additional 365 days	$0	100% of Medicare eligible expenses	$0[4]
• Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE[1] You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but [$128] a day	Up to [$128] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

[1] A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

[2] This high deductible plan pays the same benefits as Plan F after one has paid a calendar year [$1,900] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are [$1,900.] Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible..

[3] $0 indicates your liability for covered charges. You are responsible for all other noncovered charges.

[4] Notice: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid for Medicare covered items or services.

HIGH DEDUCTIBLE PLAN F (continued)

Medicare (Part B) - Medical Services - Per Calendar Year

SERVICES	MEDICARE PAYS	AFTER YOU PAY [$1,900] DEDUCTIBLE,[2] PLAN PAYS	IN ADDITION TO [$1,900] DEDUCTIBLE,[2] YOU PAY[3]
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT Such as: physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First [$135] of Medicare-approved amounts[1]	$0	[$135] (Part B Deductible)	$0
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (Above Medicare-approved amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next [$135] of Medicare-approved amounts[1]	$0	[$135] (Part B Deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

Parts A and B

SERVICES	MEDICARE PAYS	AFTER YOU PAY [$1,900] DEDUCTIBLE,[2] PLAN PAYS	IN ADDITION TO [$1,900] DEDUCTIBLE,[2] YOU PAY[3]
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
• Medically necessary skilled care services and medical supplies	100%	$0	$0
• Durable medical equipment			
First [$135] of Medicare-approved amounts[1]	$0	[$135] (Part B Deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0

[1] Once you have been billed [$135] of Medicare-approved amounts for covered services, your Part B Deductible will have been met for the calendar year.

[2] This high deductible plan pays the same benefits as Plan F after one has paid a calendar year [$1,900] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are [$1,900]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

[3] $0 indicates your liability for covered charges. You are responsible for all other noncovered charges.

HIGH DEDUCTIBLE PLAN F (continued)

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY [$1,900] DEDUCTIBLE,[2] PLAN PAYS	IN ADDITION TO [$1,900] DEDUCTIBLE,[1] YOU PAY[2]
FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First [$250] each calendar year	$0	$0	[$250]
Remainder of charges	$0	80% of a lifetime maximum benefit of [$50,000]	20% and amounts over the [$50,000] lifetime maximum

[1] This high deductible plan pays the same benefits as Plan F after one has paid a calendar year [$1900] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are [$1900]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

[2] $0 indicates your liability for covered charges. You are responsible for all other noncovered charges.

PLAN J

Medicare (Part A) - Hospital Services - Per Benefit Period

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY[2]
HOSPITALIZATION[1] Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [$1,024]	[$1,024] (Part A Deductible)	$0
61st thru 90th day	All but [$256] a day	[$256] a day	$0
91st day and after: • While using 60 lifetime reserve days	All but [$512] a day	[$512] a day	$0
• Once lifetime reserve days are used: • Additional 365 days	$0	100% of Medicare eligible expenses	$0[3]
• Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE[1] You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but [$128] a day	Up to [$128] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

[1] A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

[2] $0 indicates your liability for covered charges. You are responsible for all other noncovered charges.

[3] Notice: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid for Medicare covered items or services.

PLAN J (continued)

Medicare (Part B) - Medical Services - Per Calendar Year

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY[2]
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT Such as: physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First [$135] of Medicare-approved amounts[1]	$0	[$135] (Part B Deductible)	$0
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (Above Medicare-approved amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next [$135] of Medicare-approved amounts[1]	$0	[$135] (Part B Deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

[1] Once you have been billed [$135] of Medicare-approved amounts for covered services, your Part B Deductible will have been met for the calendar year.

[2] $0 indicates your liability for covered charges. You are responsible for all other noncovered charges.

PLAN J (continued)

Parts A and B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY[2]
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
• Medically necessary skilled care services and medical supplies	100%	$0	$0
• Durable medical equipment			
First [$135] of Medicare-approved amounts[1]	$0	[$135] (Part Deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0
AT-HOME RECOVERY SERVICES—NOT COVERED BY MEDICARE			
Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
• Benefit for each visit	$0	Actual charges to [$40] a visit	Balance
• Number of visits covered (Must be received within 8 weeks of last Medicare Approved visit)	$0	Up to the number of Medicare Approved visits, not to exceed 7 each week	
• Calendar year maximum	$0	[$1,600]	

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY[2]
FOREIGN TRAVEL - NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First [$250] each calendar year	$0	$0	[$250]
Remainder of charges	$0	80% of a lifetime maximum benefit of [$50,000]	20% and amounts over the [$50,000] lifetime maximum
PREVENTIVE MEDICAL CARE[3] BENEFIT—NOT COVERED BY MEDICARE			
Some annual physical and preventive tests and services administered or ordered by your doctor when not covered by Medicare			
First [$120] each calendar year	$0	[$120]	$0
Additional charges	$0	$0	All costs

[1] Once you have been billed [$135] of Medicare-approved amounts for covered services, your Part B Deductible will have been met for the calendar year.

[2] $0 indicates your liability for covered charges. You are responsible for all other noncovered charges.

[3] Medicare benefits are subject to change. Please consult the latest Guide to Health Insurance for People with Medicare.